

# Addressing the Social Determinants of Health in the Nordic Countries: Wicked or Tame Problem?

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This project studied how the Nordic countries apply policies to address the social determinants of health, and such a perspective demands awareness of the structural conditions for health. The project applied a qualitative approach using documents and interviews as data, and we explored whether the countries had comprehensive policies, if they included whole-society approaches, and if the policies were committing. Social inequalities may be termed a wicked problem, meaning that they are embedded in political conflict and thus it is difficult to find sustainable policy solutions. All countries have formulated political aims to reduce social inequalities, and such measures are mostly at the local level addressing lifestyle issues or social problems. The wider determinants of health are often not acknowledged, and policy problems are redefined from wicked to tame problems, which are less complex and conflicting.

## Introduction

In this paper we present findings from a project studying policies to reduce social inequalities in health in the Nordic countries. The project – “Tackling Health inequalities locally: the Scandinavian experience” (ScanHeiap) – took place from 2014 to 2016 and collected data from Denmark, Norway, and Sweden and concluded with 11 recommendations for policies to reduce social inequalities in health (Diderichsen et al. 2015). The recommendations took their point of departure from the social determinants of health as outlined in the WHO commission (WHO 2008).

The Nordic arena for public health initiated a follow up to the ScanHeiap project called “Equal Health - Prerequisites at National Level”. The aim of this second project was to contribute to better conditions for working towards increased equality in health at the national level in the Nordic countries. Under this umbrella, four sub-projects were organised. Of these, “Nordic national policies

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to increase equity in health” was led by the first author of this paper and the results are presented here and include data from Denmark, Finland, and Sweden.<sup>1</sup>

### *The social determinants of health*

The Rio Declaration on Social Determinants of Health (WHO 2011) states:

*“Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years’ experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health.”*

The determinants’ perspective on health inequalities demands an awareness of the structural conditions creating social inequalities that lead to social inequalities in health. Important policies that attempt to influence the social determinants are, for example, tax policies and housing policies (WHO 2008).

There is substantive evidence of a social gradient in health inequalities, demonstrating that health becomes worse as you move down the socioeconomic scale (Davies & Sherriff, 2011; Graham, 2000). Approaches targeting only the most disadvantaged are unlikely to be effective in levelling out the gradient and might even contribute to an increase in health inequalities. National policies thus need to be comprehensive and focus on the upstream determinants of health inequities (such as income, education, and living and working conditions). It is also argued that universal measures aimed at the whole population should be the main policy strategy. In addition, it is argued that targeted measures aimed at disadvantaged groups will also be required (WHO 2008). This combination of approaches has been termed “proportionate universalism” (Marmot 2010).

Addressing the social determinants of health is, of course, demanding in many ways. It requires an awareness of the societal conditions that influence citizen’s health and wellbeing and demands structural measures in many sectors of society. Reducing social inequalities in health is thus a complex problem that is often difficult to solve, a so-called wicked problem.

### *Health inequalities – a wicked problem*

A wicked problem has been defined in the following way:

*“A wicked problem is a social or cultural problem that is difficult or impossible to solve*

1. The other subprojects were “Intersectoral collaboration at the Ministry level”, led by the Public Health Agency of Sweden; “Common Nordic indicators for reducing social health inequalities”, led by the Norwegian Institute of Public Health; and “Policy briefs on reducing social health inequalities”, led by the National Institute for Health and Welfare, Finland.

*for as many as four reasons: incomplete or contradictory knowledge, the number of people and opinions involved, the large economic burden, and the interconnected nature of these problems with other problems” (Rittel and Webber 1973).*

Solving a wicked problem demands intersectoral collaboration on many levels. However, because governments are sectorised and organised in so-called silos, this demand is difficult to meet. In addition, the wicked problems are often highly contested and debated policy areas characterised by political conflicts. These conflicts include both the definition and the solutions to the problem and might thus result in ambiguous compromises (Christensen et al. 2019).

Social inequalities in health may be characterized as a wicked problem because they are embedded in political conflict and this makes it difficult to find sustainable policy solutions (Feyarts et al. 2017).

### *The Nordic welfare states*

Reducing social inequalities was one of the main aims in the development of the Nordic welfare states, which have been described as social democratic welfare states (Esping-Andersen 1990).

The WHO Commission on the Social Determinants of Health suggested structural measures to level the social gradient in health, and these measures may be characterised as “welfare state policies”. The commission pointed to the Nordic countries with their comprehensive welfare states as an ideal (WHO 2008). In an international perspective, the Nordic countries have a high standard of living and small social and economic differences. The Nordic model has been challenged in recent decades, mostly because of a turn of policy in the direction of neo-liberalism with its emphasis on deregulation, privatisation, and globalisation. Despite a long tradition of reducing social inequalities by introducing welfare policies and structural measures, social inequalities have increased over time in all of the Nordic countries (Norwegian government 2017).

In the current project, we explored national policies in the four countries, and based on the social determinants perspective we formulated the following research questions:

Which institutions at the national level are responsible for addressing social inequalities in health? It is necessary to take a whole-of-society approach to addressing the social determinants of health, and this builds on the understanding that addressing social inequalities is a responsibility for all sectors of society. This is also supported by other research, both globally and in the Nordic countries (WHO 2008, Carey and Crammond 2015, Sundhedstyrelsen 2011, Dahl et al. 2014, SOU 2017:4). Included in this overall question were sub questions about intersectoral collaboration, both horizontal and vertical.

theme

In addition to a whole-of-society approach, we ask how do the Nordic countries apply a comprehensive approach to addressing social inequalities? A comprehensive approach requires action to reduce social inequalities by developing policies to level the social gradient in health. Universal measures are key in this process. In addition, targeted measures aimed at disadvantaged groups will also be required (Marmot 2010).

Our third research question was What legislation and policies are in place? The aim of this question was to explore national commitments to addressing the social determinants of health.

The findings from the project provided us with some answers regarding national strategies and whether they meet the requirements for addressing the social determinants of health. In the discussion section we will apply an analytical lens where we discuss whether the conceptualisation of this policy area as a wicked problem might influence the strategies applied by the Nordic countries.

## Methods and data

The project applied qualitative methods, which included document analysis and expert interviews. Content analysis was performed for the documents, which in this case meant analysing them from the perspective of our research questions (Flick 2009, Krippendorff 2004). The analysed documents were national policy documents, including white papers, green papers, reports, etc. Such documents hold a high level of credibility because they reflect the current policy in the country (Flick 2009). The documents studied are listed in the references section.

We also interviewed policy makers working with issues related to social inequalities in health in Denmark, Finland, Norway, and Sweden. The public health arena of the Nordic Council of Ministers provided contact persons in each country. We also applied the so-called snowball method to find interviewees (Brinkmann and Kvale 2014). The institutions have somewhat different roles, and this is also reflected in the sample of informants interviewed. The institutions from which we interviewed persons were the ministries for health and social affairs, other relevant government institutions, public health institutes, and stakeholder associations for municipalities. We interviewed 4–7 persons in each country (Table 1).

The interviews lasted for about one hour each and were transcribed. For each country, interviews were numbered and are referred to in the text by country and number. To ensure data credibility, both authors worked with the coding and interpretation of the transcribed interview data.

In all countries, the ministries of health are responsible for policy development in this field, even if there is an explicit aim that all sectors of society

should be responsible. Table 2 gives an overview of the administrative bodies responsible for public health policies in the Nordic countries, including policies to reduce social inequalities in health.

Table 1. Interview respondents by institutional belonging

	Ministries	Directorate/ Public Health authorities	Local government associations	Others*
Denmark	2	2	1	2
Finland	1	1		2
Norway	1	3		
Sweden		2	2	1

\*The category “others” include informants who were researchers, former employees and politicians.

Table 2: Overview over national administrative bodies important in public health policies

	Denmark	Finland	Norway	Sweden
<b>Ministry</b>	Ministry of Health	Ministry of Social Affairs and Health	Ministry of Health and Care	Ministry of Health and Social Affairs
<b>Directorate</b>	Danish Health Authority		Directorate of Health	Public Health Agency
<b>Knowledge/ research institution</b>	National Institute of Public Health	National Institute for Health and Welfare	Norwegian Institute of Public Health	
<b>Regional level</b>	5 regions Region stakeholder association: Danish regions	19 hospital municipal sub regions	19 regions	21 regions
<b>Local government stakeholder organisation</b>	Local Government Denmark	Association of Finnish Local and Regional Authorities	The Norwegian Association of Local and Regional Authorities	Swedish Association of Local Authorities and Regions

theme

## Findings

### *Whole-of-society approach*

Finland and Norway both have public health acts. Finland's act was adopted in 1972 but has from 2010 been included in the Health and Care Act. Norway's act is from 2012, and more so than in the other countries it explicitly embraces the social determinants perspective. The other countries also have policies in place, but not acts, which are the most committing.

Even though all countries have formulated national policies to reduce social inequalities in health, interviewees in all the countries reported that there are no permanent formal structures in place for collaboration and that the collaboration is mostly ad hoc or project based.

In Denmark, implementing policies to reduce social inequalities in health is a responsibility for the Danish Health Authority. In the interviews, it was particularly emphasised that the Danish Health Authority prioritises their responsibility to develop and promote measures within the health sector, which is the field they are responsible for:

*“Our responsibility is the health services. We are a professional authority. We develop the guidelines and are responsible for the overall planning.”* (Denmark 1, 2)

In Finland, the interviewees stated that even if Finland has a public health act, it has over the years been emptied of its paragraphs on substantial policies:

*“The municipalities are mandated with the responsibility to have an evidence base for their policies and to anchor responsibilities with a leading actor.....We have nothing similar at the national level. Nothing is required from the ministries, really.”* (Finland 2)

In Norway there is a consciousness about policies to address the social determinants of health, in accordance with the public health act. However, also in Norway it is difficult to achieve a joint commitment across sectors:

*“[...] We have a strong ministerial responsibility, and themes and cases are sorted under different ministries, but there is no collective responsibility for the government as a whole.”* (Norway 1)

In Sweden there is a collective government responsibility, and no single ministry is responsible as in the other countries. The minister of finance and the public health minister together were at the receiving end when the white paper on social inequalities was released in 2018. This might have an important symbolic value, but it does not mean that inter-sectoral work is the most prioritised

in public health policies. As in the other Nordic countries, the Swedish national policy is also reported to be fragmented:

*“Coordination not so good between ministries at the government level.”* (Sweden 3)

### *A comprehensive approach*

All of the Nordic countries apply both universal and targeted measures in their public health policies. Stakeholders at the national level agree on the need to apply a comprehensive approach to increase social equality in health. This involves policies to influence the determinants of health, and it involves a balance between universal and targeted measures. However, the actual public health policies vary between the countries. In Denmark, the main measures are related to improving healthy lifestyles, and for the Danish Health Authority the main focus is on individual prevention. This means lifestyle issues like diet, physical activity, smoking, and alcohol use:

*“Our approach is an individualistic one. We focus on what families can do to improve their health. We can have a social determinant perspective, but our task is to address issues that are the responsibility for the health services.”* (Denmark 1, 2)

In Finland, there is an acknowledgement of the social determinants, but it is to a lesser extent developed into concrete policies and measures. In practice, individual lifestyle measures are dominating:

*“I think Finland is, as well as the other Nordic countries, good at developing universal approaches, [Government grant projects] report to us once a month about how they are proceeding on projects. Their approaches vary, but they are developing targeted approaches.”* (Finland 2)

The Norwegian determinant perspective in policies as well as the balance between universal and targeted measures were made very clear by an interviewee who looked at the policies this way:

*“The determinant perspective...is directed at the universal arenas...like work and education [...] while we also need the targeted measures, they are becoming visible now, directed at poor children and children from migrant families as well as those excluded from the work force.”* (Norway 3)

However, in recent policy documents, there is an increased emphasis on individual measures (Ministry of Health and Care Services, 2019).

theme

In Sweden, there is an explicit focus on social inequalities and both universal and targeted measures:

*“[...] we started talking about the determinants – that is what Michael Marmot says, it is where we are born, grow up, get educated, live and grow old – it is under all these circumstances that our health is created. [...] We also develop policies towards health behaviour; alcohol, drugs, and tobacco as well as suicide prevention and sexual and mental health.”*  
(Sweden 2)

### *Long-term commitment and legislation*

Even though the Nordic welfare states are built on an ideology of redistribution among social groups, the policies to achieve social equity do not have the same momentum in the countries. In Denmark, there has been no strong political focus on the social determinants, and the individual focus on prevention of unhealthy lifestyles has been predominant. Health inequalities are mainly described as a problem to solve for health professionals, rather than a political problem:

*“If you look at the public health programmes issued by different governments, they are not so different. They address the same factors and the same measures. Some might emphasise social inequalities more than others, but the tools are still the same.”* (Denmark 1, 2)

In Finland, reducing social inequalities is formulated in policies, but these inequalities do not play an important role in concrete policy making. The proposed measures particularly recognise vulnerable and disadvantaged groups as those in need of support. Furthermore, the proposed measures are not articulated in an explicit and concrete way:

*Everybody in the Parliament has said that social inequality or inequity...should be improved. ...But when you go to the political debates, like in every country, I think that the more left you go the more you hear that the government is not doing enough in this issue and the current government is saying that yes, this is a great concern for us.”* (Finland 1)

In Norway, the Directorate for Health has an important role in supporting the municipalities in the implementation of the Public Health Act. A central element of the act is the way it communicates with the Planning and Building Act (PBA). This is an important judicial steering mechanism:

*“One paragraph in the Planning and Building Act explicitly says something about social inequalities. That is worth its weight in gold.... You communicate much broader in municipalities when you refer to this act. . That is what is right, I think, because the PBA*

*is the most important law to develop the municipalities. The Public Health Act supports this.” (Norway 2)*

Sweden was the first of the Nordic countries to formulate policies with the report “Health on equal terms” in 2003 (Diderichsen et al. 2015). The overarching aim of the Swedish public health policy is to create social conditions that ensure good health on equal terms for the whole population. However, social equality as a perspective has not prevailed in public health policy development or implementation:

*“We have had a national public health policy for quite some time, and this has been more successful at the local and regional levels than at the national level. Nevertheless, health inequalities have grown.” (Sweden 2)*

In all of the Nordic countries, social inequalities in health are acknowledged as a problem, and all countries have political aims to reduce these inequalities. However, in none of the countries are there strong incentives to formulate these problems in terms of the social determinants of health and to formulate policies based on this acknowledgement. Rather, the health sector still seems to be the dominant actor, and individual measures still seem more important than structural approaches.

## **Discussion**

As pointed out above, social inequalities in health may be described as a wicked problem. This means that the definitions of the problem may cause disagreement regarding both the causes and the solutions to the problem. Feyaerts et al. (2017) make the point that policies to reduce social inequalities in health have a tendency to “drift downstream”, which means towards policies addressing individual lifestyle factors and not the social determinants of health. In other words, the wicked problem is being redefined into a tame one, meaning that the problem is being redefined into a simpler, less contested problem, and thus presenting solutions that are manageable, often by the health services. In practice this will often mean individual or group-related measures.

In this sense, it is fair to state that even if problems related to health inequalities are conceptualised in terms of social determinants of health in national policy papers, the actual policy measures are seldom in line with these concepts. In short, they are not comprehensive and do not include whole-of-society measures. This, we believe, is a result of the lack of commitment for policies addressing the social determinants of health.

There are, however, some differences between the countries regarding the

direction of the policy. Both Finland and Norway have adopted public health acts, and both acts mandate the municipalities to apply a health-in-all-policies approach and to reduce social inequalities in health. However, there are some differences in the implementation procedures of the acts. In Norway, the national government is auditing whether the municipal plans follow the guidelines of the act. In Finland, the implementation is mostly left to the municipalities. In both countries, the municipalities still have a high degree of freedom to make priorities, and there are few sanctions if they do not follow up all the intentions of the act. In Sweden, there is a strong focus on the social determinants of health, particularly after the adoption of the government white paper in 2018. In Denmark, the individual focus on reducing social inequalities has been the focus of policy over a substantial period of time.

Regardless of these differences, we find that the wickedness of the problem of health inequalities is being under-communicated in all of the Nordic countries. Measures are mostly at the local level and have the character of a redefinition of the wicked problems into tame problems, focusing on individual lifestyle issues or social problems that may be solved either by the health services or by collaboration between local services. This means that the wider determinants of health are not acknowledged in national policies and measures.

## Conclusions

Policymaking in the field of social inequalities in health is a clear example of a complex policy field, where decision-making first and foremost is constrained by its intrinsic 'wickedness'. Even more than its complexity and interconnectedness, it is the intrinsic controversial nature that constrains the policy progress (Feyaerts et al. 2017).

In our study we found that even though all of the Nordic countries have policy aims to reduce social inequalities, the problems sometimes have been redefined into tame problems. If the countries seriously aim to reduce social inequalities, a policy shift is needed, which includes a revitalisation of the Nordic model. This would include structural and universal policies and measures with the explicit aim to reduce social inequalities in health by levelling the social gradient and addressing the social determinants of health. Recognition of the wickedness of the issue, political will, and institutional arrangements fit to tackle the problem are required, and legislation and clear policy commitments thus need to be in place.

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